MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 18, 2004
10:06 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Review of CMS's estimate of the 2005 payment update for physician services - Kevin Hayes

MR. HACKBARTH: Next up is -- as you'll recall from years passed, we need to review the CMS estimate of the physician update which is finally published I think in June; is that right?

DR. HAYES: Our review is published in the June report and then update itself in November.

MR. HACKBARTH: So this is our look at this for our June report.

DR. HAYES: Yes.

Thank you. Our task then is to review this early estimate of the update now for 2005. It's a calculation that CMS goes through according to a statutory formula that compares actual spending for physician services with a target. That target in turn is determined by what's known as the sustainable growth rate, which is a growth rate for spending on these services.

There has been a new development here in that the Medicare Modernization Act established a minimum for the physician update for both 2004 and 2005, a minimum update of 1.5 percent. So in a sense, the Congress chose to override the statutory formula for those two years.

CMS still, however, needs to go through the calculation and determine whether or not under the formula the update would exceed that 1.5 percent minimum that was in the law. That's the core of what's before us today is their calculation of what the update would be in the absence of the MMA minimum of 1.5 percent. They have done so and have calculated an update under the formula of minus 3.6 percent. So we want to then go over their calculations and review that result.

All of this would be recognizing that the numbers involved in the calculation are subject to change and may be very different between now and November when CMS goes through the calculations that will actually determine what the update will be for 2005.

In your mailing materials for this meeting you had a draft of our review as it would appear in the June report. It is really a technical review of the details of the calculations and the estimates that were used for those calculations. That's pretty much what we have.

So just to review, the process that CMS goes through here with the statutory formula is really a two-part process. First, there is an estimate of that sustainable growth rate which determines the target level of spending

for physician services. Then CMS calculates what the update would be under the formula by comparing an estimate of actual spending for physician services with the target that's determined by the SGR.

So looking first at their estimates for the sustainable growth rate, the estimate is as you see it here. It's really a process, given that we're looking for a target rate of growth in spending, the sustainable growth rate needs to account for two things then. It needs to account for changes in prices and it needs to account for changes in the quantity of services. So we have a measure of input prices here that CMS is using, estimating at this point of 2.6 percent.

This would be a weighted average of three types of price changes. One would be from the Medicare economic index which you're familiar with. It's used in our recommendations about the payment update for physician services. It measures input prices for physician services, rents and salaries and that kind of thing. Then we also have considered here, as part of the definition of spending for physician services we have spending for Part B drugs. These would be the injectable drugs that are covered under Part B and often administered in physician offices. So there is a consideration of those price changes in here as well. And finally, changes in payment rates for laboratory services, those services in our and CMS's definition of physician services, services often provided in physician offices. So we get this 2.6 percent here for input prices.

Then moving over to the quantity side we start with just enrollment, the number of beneficiaries who would be using services in Medicare fee-for-service. We see here a minus sign in front of this factor of minus 0.2 percent. We have not seen minus signs in these calculations for several years now, but this reflects an assumption that there will be some shift in enrollment from Medicare fee-for-service to Medicare Advantage consistent with policy changes that were in the MMA.

Third up we have growth in real GDP per capita. That's the allowance in the SGR for growth in use of physician services per beneficiary. The MMA changed this factor somewhat. It's now moved from what was year-to-year changes in GDP growth to a 10-year moving average. So this is CMS's calculation of a 10-year moving average. It's intended to smooth out changes in this factor and reduce the volatility ultimately in the SGR itself.

When there are changes in the benefit package there is a factor here for changes in spending that would be due to law and regulations. None are anticipated at this point for 2005, so CMS is estimating a factor of zero for this. All this totals up to 4.6 percent, and that would be

the target rate of spending growth for physician services of the year 2005.

MR. HACKBARTH: Kevin, let me just leap in a second. I don't want to deny any commissioner the opportunity to review all of the component parts. I for one would be willing to stipulate that 1.5 percent is probably going to be greater than the number that the SGR formula would produce. Is there anybody who would like -- Alan, would you like to go through all the details? I know you've followed this very closely?

DR. NELSON: I would like to just raise one question because I think that if this is going to appear in our June report we have to appear thoughtful and reasonable. A zero percent for changes in law and regulation denies the impact of the MMA, which includes the entrance history and physical that's going to find a certain amount of stuff as cholesterol screening and so forth.

Now it may be that in calculating the sustainable growth rate that they specifically are looking only at law that's passed in 2005. But in the estimated update calculation there's a 0.8 percent figure attached to that and so I have two questions.

Number one, Kevin, on the bottom of page two you say, MedPAC finds no reason to question CMS's assumptions about factors that determine the update. Then going on on page three we say, an estimate of no change in spending due to law and regulation is valid as long as the Congress, and so forth. I think we should at least qualify the fact that we expect some increase in spending and volume as a result of legislation that will become active in 2005.

I wonder if the legislative adjustment of 0.8 is a high enough figure. I wonder if we ought not flatly say, yes, we go along with this when there are good and clear reasons for us to express some reasonable doubt about the assumptions.

DR. HAYES: The 0.8 factor that's shown here is a legislative adjustment that was really a carryover from the Balanced Budget Refinement Act of 1999. There were some technical changes made in the SGR formula at that time and there has been a series of these legislative adjustments that have to be incorporated in the calculations over a period of years. This is the final one which is 0.8.

DR. NELSON: I guess I'm back to my original question then as to whether we should express some level of disagreement with an assumption that says there won't be an increase in volume as a result of legislation, when indeed there will. There is certain to be. I think it will probably be pretty substantial as a result of the screening law changes.

MR. HACKBARTH: What's the effective date of that?

DR. NELSON: 2005. The cholesterol screening applies to everybody. There are other screening changes, but the screening physical for new beneficiaries, as I understand it from the text here, begins in 2005.

MR. HACKBARTH: So we don't need to dwell on the details right now, but on the face of it it seems like there might in fact be some numbers in that slot. Could you just investigate, Kevin, why they're not?

DR. HAYES: Yes.

DR. ROWE: Since we want to be clear and objective and thoughtful, should we comment on the difference between minus 3.6 and plus 1.5?

DR. NELSON: Only to say that we favor it.

[Laughter.]

MR. HACKBARTH: Let me just say a word about how we've handled this in the past, just as a reminder. We've taken this up basically as a technical exercise in the past where we review the basic calculation and, at least to my recollection, have always said it more or less make sense. In the past there have been some occasions where the update was not in accord with MedPAC recommendations and we've said something to the effect that, yes, the calculation is right but we think a modest update for physicians would be appropriate for the year in question. In this instance, MMA overrode the formula and provided the 1.5 percent update, which I think is consistent with our recommendation in the March report.

So what I would say is we just note that fact and move on, and for example, not use the letter as an opportunity to pound the anti-SGR drum again. We've not used it in the past that way and I think that was a smart move that we ought to continue.

DR. ROWE: What happens going forward since this formula, which we want to get rid of anyway but let's say persists or the ghost of it returns, and it's got these adjustments in it, so that if the physicians were underpaid it adjusts for that, and if they were overpaid it adjusts for that. Now we're going to have two years or at least one year where there's going to be a 5 percent difference between the calculation and what the payment is. Is that going to be corrected for going forward so there's going to be a reduction in the payment increases?

MR. HACKBARTH: We're getting further and further away from the underlying SGR curve.

DR. MILLER: Or to put it differently, to the extent that volume is growing, that can affect the update, and to the extent that Congress has intervened and given a higher update than the SGR would, that also counts and then gets taken out over time.

DR. STOWERS: I just want to be sure though that

this doesn't get interpreted as even though we believe that they're calculating the SGR correctly and we're okay with the update, that we're totally giving up the idea that this minus 3.6 is not enough. Just so that's not interpreted as us -- and I think it almost could be, that, yes, we're going to go with what Congress said but -- we don't want to come across as we've dropped our recommendation from a plus 2.5 to a minus 3.6.

MR. HACKBARTH: I understand your concern and we will write the letter so that it's clear what we're concurring with and what we're not.

Any others? Okay, I think we've covered all the important points. Kevin, anything else from your perspective?

DR. HAYES: No.